SECTION 2
ADA 2002 CLAIM FILING INSTRUCTIONS

The ADA 2002, 2004 version dental claim form should be typed or legibly printed. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services
P.O. Box 5300
Jefferson City, MO 65102

Or submitted electronically at www.emomed.com

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1-2.		Not required.
3*	Primary Payer Information	Enter Name, Address, City State and Zip Code for the insurance company or third-party payer.
4-11**	Other Coverage	Required only if recipient has a second dental policy. Leave blank if there is no other Dental Coverage
12-17**	Primary Insured Information	When verifying the patient's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field #32, section: "Other Fees". Leave blank if there is no other dental coverage.
18-19.		Not required.
20*	Patient Name	Enter the patient's last name, first name and middle initial as shown on the patient's Medicaid ID card. Enter the patient's street address, city of residence and state.
21.	Date of Birth	Not required.
22.	Sex	Not required.

23*	Patient ID/Account Number	Enter the patient's eight-digit Medicaid or MC+ identification number (DCN) exactly as shown on the patient's ID card.
24*	Procedure Date	Enter the actual date services were rendered in MM/DD/CCYY numeric format. Reminder: The date of service for dentures (full or partial) is the date of placement.
25.	Oral Cavity	Not required.
26.	Tooth system	Not required.
27*	Tooth Number or Letter	Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, this field may be left blank. The valid values are: A-T Deciduous teeth 1-32 Permanent teeth AS-TS Deciduous supernumerary teeth 51-82 Permanent supernumerary teeth When billing for partial dentures, enter the tooth number of one of the teeth being replaced in this field. Alveoplasties should be billed using tooth number 10 for upper right quadrant, 20 for upper left quadrant, 30 for lower left quadrant and 40 for lower right quadrant.
28**	Tooth Surface	Enter the appropriate service code, if applicable. Otherwise, leave blank. The valid values are: M-Mesial D-Distal O-Occlusal L-Lingual I-Incisal F-Facial B-Buccal
29*	Procedure Code	Enter the five-digit procedure code for the service performed as well as any applicable modifiers.
30**	Description	Only required in specific situations.
31*	Fee	Enter the provider's usual and customary fee for the procedures(s) performed. Do not subtract the copay or coinsurance amounts from the charge.

32.	Other Fees	When other charges are applicable to dental services provided, this field must be reported. Enter the amount here.
33*	Total Fee	Enter the total of the charges shown.
34.	Missing Teeth	Not required.
35**	Remarks	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
36-38		Not required.
39**	Number of Enclosures	Complete whether or not radiographs, oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore, no possible attachments are missing.
40.	Is treatment Orthodontics?	If no, skip to #43. If yes, answer #41.
41.	Date Appliance placed	Date orthodontic appliance was placed.
42.	Months of Treatment Remaining	Not required.
43.	Replacement of Prosthesis	This item applies to crowns and all fixed or removable prosthesis: a. If claim does not involve a prosthetic restoration check "no" and proceed to #45. b. If claim is for the initial placement of a crown or fixed or removable prostheses, check "no" and go to #45 c. The patient has previously had these teeth replaced by a crown, check "yes" and go to #44.
44.	Date of Prior Placement	Complete if the answer to #43 was yes.
45.	Treatment Resulting From	If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box and proceed to items #46 & 47. If services are not the result of an accident, skip to item #48.
46.	Accident Date	Enter the date on which the accident in #45 occurred. Otherwise leave blank.

47.	Auto Accident State	Enter the state in which the auto accident in #45 occurred. Otherwise leave blank.
48	Name, Address, City, State	Enter the name and complete address of the billing dental provider.
49*	Provider ID#	This number is an identifier assigned to the *billing* dentist or dental entity.
50.	Dentist License #	Not required.
51.	Dentist SS# or T.I.N.	Not required.
52.	Phone Number	Enter provider's phone number
53.*	Signature & Date	Signature of treating dentist and the date form is signed.
54.*	Provider ID#	This number is an identifier assigned to the *treating* dentist or dental entity.
55.	License #	Not required.
56.*	Address, City, State, MO	Enter the name and complete address of the dentist or dental entity.
57.	Phone Number	Enter treating dentist phone number.
58.	Treating Provider Specialty	Not required.